APPENDIX A-1:

Data Abstraction Tool: Intrapartum Antibiotic Prophylaxis for GBS (MAT-1)

INSTRUCTIONS: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Use of ***italic and underlined font*** throughout this tool indicates updated text has been inserted. The capital letters in parenthesis represents the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) _____
2. Provider ID (PROVIDER-ID) _____ (AlphaNumeric)
3. First Name (FIRST-NAME) _____
4. Last Name (LAST-NAME) _____
5. Birthdate (BIRTHDATE) ___ ___ -___ ___ - ___ ___ ___ ___
6. Sex (SEX) □ Female □ Male □ Unknown
7. Postal Code What is the postal code of the patient's residence? (POSTAL-CODE) __ __ __ __ __ __ __ __ __
   (Five or nine digits, HOMELESS, or Non-US)
8. Race Code - (MHRACE) (Select One Option)
   - □ R1 American Indian or Alaska Native
   - □ R2 Asian
   - □ R3 Black/African American
   - □ R4 Native Hawaiian or other Pacific Islander
   - □ R5 White
   - □ R9 Other Race
   - □ UNKNOW Unknown/not specified
9. Ethnicity Code - (ETHNICODE) __ __ __ __ __ __
   (Alpha 6 characters, numeric is 5 numbers with – after 4th number)
10. Hispanic Indicator- (ETHNIC)
    - □ Yes
    - □ No
11. Hospital Bill Number (HOSPBILL#)__ __
    (Alpha/Numeric – field size up to 20)
12. Patient ID (i.e. Medical Record Number) (PATIENT-ID) __ __ __ __ __ __ __ __ __ __ __ __ (Alpha/Numeric)
13. Admission Date (ADMIT-DATE) ___ ___-___ ___-___ ___ ___ ___
14. Discharge Date (DISCHARGE-DATE) ___ ___-___ ___-___ ___ ___ ___
15. Was the patient involved in a clinical trial during this hospital stay relevant to the measure set for this admission? (CLNCLTRIAL)
    - □ Yes (Review Ends)
    - □ No

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16. What was the patient's discharge disposition on the day of discharge? (DISCHARGDISP)
(Select One Option)

□ 01 = Home
□ 02 = Hospice- Home
□ 03 = Hospice- Health Care Facility
□ 04 = Acute Care Facility
□ 05 = Other Health Care Facility
□ 06 = Expired
□ 07 = Left Against Medical Advice / AMA
□ 08 = Not Documented or Unable to Determine (UTD)

17. What is the Medicaid Payer Source? (PMTSRCE)

☐	103	Medicaid (includes MassHealth)
☐	104	Medicaid Managed Care – Primary Care Clinician (PCC) Plan
☐	108	Medicaid Managed Care- Fallon Community Health Plan
☐	110	Medicaid Managed Care – Health New England
☐	113	Medicaid Managed Care – Neighborhood Health Plan
☐	118	Medicaid Mental Health & Substance Abuse Plan- Mass Behavioral Health Partnership
☐	207	Network Health- Cambridge Health Alliance MCD Program
☐	208	HealthNet – Boston Medical Center MCD Program
☐	119	Medicaid Managed Care Other (not listed elsewhere)
☐	98	Healthy Start
☐	178	Children's Medical Security Plan (CMSP)

18. What is the patient's MassHealth Member ID? (MHRIDNO)
(All alpha characters must be upper case)

_____

19. Does this case represent part of a sample? (SAMPLE)

□ Yes
□ No

20. What was the infant's gestational age at the time of delivery? (GESTAGE)

_____ *If < = 24 weeks gestation (Review Ends)*

(in completed weeks; do not round up*)* (enter 2 digit numeric value with no leading 0, or UTD)

21. At what time was the mother admitted to the labor and delivery unit? (TIMEADMLABDEL)

__ __:__ __ (military format – HH:MM or UTD)

22. Did the patient receive an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery? (PRENINFANTIB)

□ Yes (Review Ends)
□ No

23. Was a Cesarean Delivery prior to onset of labor with intact membranes performed? (CDELIVERY)

□ Yes (Review Ends)
□ No

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24. On what date was the infant delivered? (INFDELDATE) ___ ___-___ ___-___ ___ ___ ___ (MM-DD-YYYY or UTD)

25. At what time was the infant delivered? (INFDELTIME) __ __:__ __ (military format – HH:MM or UTD)

26. Did the mother deliver a live newborn? (DELLIVENEB)
    - □ Yes
    - □ No (Review Ends)

27. Previous infant with invasive GBS disease? (PREVINFGBS)
    - □ Yes (go to question # 30)
    - □ No

28. Did the mother have GBS bacteriuria at any time during this pregnancy? (GBSBACTPREG)
    - □ Yes (go to question # 30)
    - □ No

29. The result of the mother's vaginal and rectal screening culture for GBS at 35-37 weeks gestation or within 5 weeks prior to birth was? (GBSRSLTS)

    Select One
    - □ Positive (go to question # 30)
    - □ Negative (Review Ends)
    - □ Unknown (If selected, proceed to i)

        i. Gestational age at delivery was < 37 weeks? (GESTAGEWEEKS)
            - □ Yes (go to question # 30)
            - □ No

        ii. Were the amniotic membranes ruptured for 18 or more hours? (AMNMEMBRUPT)
            - □ Yes (go to question # 30)
            - □ No

        iii. Did the mother have an intrapartum temperature of ≥ 100.4 (≥ 38.0C)? (INTRAPARTTEMP)
            - □ Yes
            - □ No (Review Ends)

30. Was an IV antibiotic administered to the mother in the intrapartum period for GBS prophylaxis? (ABXINTRAPARTUM)
    - □ Yes
    - □ No (Review Ends)

31. Which IV antibiotic was administered? (NAMEABX) (Select One Option)
    - □ 1 - Ampicillin
    - □ 2 - Cefazolin
    - □ 3 - Clindamycin
    - □ 5 - Penicillin
    - □ 6 - Vancomycin

    (go to question #33)

    - □ 7 – Other (if chosen, answer maternal allergy question # 32)

    Note: (4= Erythromycin has been removed as a recommended choice for prophylaxis)

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32. Did the patient have any allergies, sensitivities, or intolerances to any of the recommended antibiotic classes for this measure? (ANTIALLERGY)

    □ Yes

    □ No (Review Ends)

33. On what date was the antibiotic administered?(DTABX) ___ ___-___ ___-___ ___ ___ ___ (MM-DD-YYYY or UTD)

34. At what time was the antibiotic administered? (TMABX) __ __:__ __ (military format – HH:MM or UTD)